PRINTED: 08/19/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING (COMPLETE					
		185273	B. WING	B. WING		C 06/29/2015	
NAME OF PE	ROVIDER OR SUPPLIER	1002.0		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	29/2015
OWSLEY	COUNTY HEALTH CARE	CENTER, INC			GHWAY 11 OONEVILLE, KY 41314		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE	
F 000	INITIAL COMMENTS		F	000			
F 281	initiated on 06/22/15 and the complaint was sure Jeopardy identified at Assessment (F281 and 483.25 Quality of Care Quality of Care at 42 Care. The Immediate 06/22/15 and was det 06/13/15. On 06/13/15 at appropractical Nurse (LPN of NovoLog 70/30 insolved however, the insulination of the NovoLog 70/30 insolved however, the insulination of the sure symptoms of hylevel) and was assessible and was assessible of 20 milligrams. The facility submitted Compliance (AOC) of Immediate Jeopardy Based on the State Solvalidation of the AOC was removed on 06/1 initiating the investigation of the AOC was removed	eximately 7:30 AM, Licensed 2) #1 administered 125 units 3ulin to Resident #1; 3vas ordered for a different 2). Interview with LPN #1 on 3 revealed she failed to verify 3 in intering the insulin. At 3 AM, Resident #1 began to 3 poglycemia (low blood sugar 3 sed to have a blood glucose 3 per deciliter (mg/dL). 4 an acceptable Allegation of 5 n 06/29/15 alleging the 5 was removed on 06/17/15. 5 urvey Agency's (SSA) 5 it was determined the IJ 6 17/15 prior to the SSA 6 ation on 06/22/15. 6 ermined to be Past CEES PROVIDED MEET	F	281			
ADODATODY	DIDECTORIS OF BROWERS	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>		TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314	00/23/2013
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F 281		nal standards of quality.	F 281		
	by: Based on interview, the facility's policies, materials it was dete have an effective sys standards of quality of three (3) sampled Review of the facility Investigation" form, of	record review, and review of procedures, and training rmined the facility failed to stem to ensure professional were maintained for one (1) residents (Resident #1). Its "Allegation Report and lated 06/14/15, revealed It insulin that was ordered for		Past noncompliance: no plan of correction required.	
	revealed she did not correct resident the conference of the confer	ere was not a divider Medication Administration desident #1 and Resident #2. administered 125 units of 1 on 06/13/15 that was #2. Resident #1 became			
	06/22/15 and was de 06/13/15. The facility Allegation of Complia alleging the Immedia 06/17/15. Based on (SSA) validation of the IJ was removed cinitiating the investigation.	(IJ) was identified on termined to exist on y submitted an acceptable ance (AOC) on 06/29/15 te Jeopardy was removed on the State Survey Agency's ne AOC it was determined on 06/17/15 prior to the SSA ation. Therefore, it was st Immediate Jeopardy.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 281	Administration- Gene of 12/18/12, revealed administered in according of the attending physic revealed residents we the medication was a methods: checking the medical record, cordinecessary verifyi with other facility personant the individual who addose should record the resident's MAR immediates was given. Review of the Americ Pharmacist handout to	s policy titled "Medication ral Guidelines," revision date medications were to be dance with the written order ician. The policy further ere to be identified before dministered by the following ne photograph attached to alling the resident by name ng resident identification sonnel. The policy revealed ministered the medication he administration on the diately after the medication an Society of Consultant itled "Insulin Injection Tips," a "double check" system	F	281	DEFICIENCY)		
	to inspect insulin prepared to inspect insulin prepared to insulin	resident. an Society of Consultant itled "Medication Pass revealed the MAR should					

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F 281	Continued From pa	<u>~</u>	F 281			
	Record review reve	aled the facility readmitted 01/15, with diagnoses which abetes, Hypertension, and				
	dated 06/01/15, rev (insulin) two (2) time	#1's Physician's Orders, realed an order for NovoLog es per day according to a on blood glucose results.				
	approximately 6:00 blood sugar was 18	#1's MAR, dated 06/13/15, at AM, revealed Resident #1's 3 milligrams/deciliter (mg/dL) sliding scale insulin to be				
	Report and Investig revealed on 06/13/ incorrect insulin." F investigation reveal Director of Nursing approximately 12:0 administered Resid approximately 7:30 ordered for Resider revealed LPN #1 st the book that conta investigation report administered the in-	ry's report titled "Allegation pation," dated 06/14/15, 15 Resident #1 "received the Further review of the ed LPN #1 contacted the (DON) on 06/13/15 at 0 PM, and reported she had ent #1 125 units of insulin at AM that morning which was not #2. The investigation further ated there was no divider in ined the MARs. The revealed LPN #1 sulin to Resident #1 without iving the medication to the				
	revealed she was lo	15 at 3:27 PM with LPN #1 poking through the diabetic tions that needed to be ad looked at Resident #1's				

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F 281	not have sliding sca #1 stated she contil MARs and saw the to be administered the mishe did not look at the MAR and there was Resident #1's and F was why she made she should have charrier to administration. Interviews on 06/22 (RN) #1 at 1:44 PM 2:05 PM, and LPN administering insuling MAR and compare least twice to ensurbeing administered interviews further resunfamiliar with a reseach resident in the would ask another stresident. Interviews on 06/22 Director of Nursing revealed LPN #1 strights of medication looked at the name ensured she administeric resident.	ts and noted the resident did alle coverage at that time. LPN mued to look through the order for the NovoLog 70/30 twice per day and edication. The LPN stated the resident's name on the son to a divider separating Resident #2's MARs and that the mistake. LPN #1 stated ecked the resident's name on of the medication. 1/15 with Registered Nurse, RN #2 at 1:55 PM, RN #3 at #2 at 2:16 PM revealed when in the nurses would look at the the medication to the MAR at the the right medication was to the right resident. The evealed if the nursing staff was sident there was a picture of the MAR book or the nurse staff member to identify the staff member to identify the look of the MAR and interest the medication, should have on each page of the MAR and istered the medication to the lented the following actions to	F 2	281		
		esident #1 was immediately) licensed nurses. The				

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F 281	the facility. The facil immediately to Resic levels continued to riblood glucose level of normal limits at 158. ordered the withhold day, at which time the again. At that time, the insulin be withheld at (06/15/15). The resimonitoring with blood hourly and the Physifollowed for Residen and Comprehensive were reviewed immed Nursing on 06/13/15 resident. 2. On 06/13/15, the the weekend nurse recheck all other diabeted administered diabeted nurse for proper administered diabeted and any possible sid had received the proeffects noted. 3. Insulin is administivalidated by an additional limits administivalidated by an additional limits and longer employers. The Quality Assur (Committee member 158 at 158 and 158 an	and the resident's re immediately notified by ity provided emergency care lent #1 and blood glucose se and within one hour the of Resident #1 was within On 06/13/15, the physician ing of insulin until the next e physician was notified the physician ordered that the gain until the following day dent continued on alert diglucose levels checked cian Orders were being the #1. The Physician Orders Care Plan for Resident #1 diately by the Director of to assure compliance for this Director of Nursing instructed manager to immediately tic residents who had been comedication by this same ministration of diabetic care to effects. All other residents per medication with no side see involved was suspended to the event on 06/13/15 and	F 28 ²		

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F 281	Coordinators, Social Pharmacy Represent review the plan outlinitial audits and review 6. An audit of the M was completed by the Unit Manager on 06/compared with the president's insulin supresident names, condivider tabs were also completed on 06/14/7. Comprehensive C residents were review (LPN) and Medical F 06/16/15. 8. On 06/13/15 and conducted for Licens medication administry Medication Administry Medication Administry Medication Administry demonstrations and to validate training on licensed nurses were return to work until the percent of the licensed work until education by return demonstrations and verify the correct resprior to administration Rights of Medication patient, the right drugs of the solution of the licensed verify the correct resprior to administration Rights of Medication patient, the right drugs of the solution of the licensed verify the correct resprior to administration Rights of Medication patient, the right drugs of the licensed verify the correct resprior to administration Rights of Medication patient, the right drugs of the licensed verify the region of the licensed verify the correct resprior to administration Rights of Medication patient, the right drugs of the licensed verify the region of the licensed verify the correct resprior to administration Rights of Medication patient, the right drugs of the license of the licen	N Unit Coordinators, MDS Services Director, and tative) met on 06/15/15 to ned herein and results of ews. ARs for diabetic residents the Director of Nursing and RN 14/15. The MARs were hysician's order and then the toply on 06/16/15. The tect room numbers, and room to validated in the audit 15. Care Plans for all diabetic twed by the MDS Coordinator the Records Director (RN) on 06/14/15, in-services were the ded Nurses regarding proper tration using the 5 Rights of tration. Return post testing were completed the on vacation and cannot training is complete and 98 the ded nurses were trained by the NDS completed and confirmed	F 281		

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F 281	on 06/13/15. 10. The Director of Manager, and the R completed medicatilicensed nurses beg 06/16/15. Observatinsulin and demonst Medication Administration are sustained compliant orders for insulin type by an additional lice administration. 11. Beginning on 06 Nursing, the RN Un Records Director, and observe at least one (Monday-Friday) and Weekend Manager, complete these obsconfirm proper procevalidation. 12. The facility's Preconduct Medication licensed nurses on nurses have been very RN Unit Manager, to Director, and the MI (Monday-Friday) and (Monday-Fri	Nursing, the RN Unit N Medical Records Director on pass observations on all inning on 06/13/15 through ion included administration of tration of the 5 Rights of tration. Licensed Nurses are the until education and return completed. To ensure the, validation of physician's the and dose will be performed the MDS Coordinators will the administration of insulin daily did the Director of Nursing, or Charge Nurse will the validation on week-ends to the dure and second nurse's The second nurse of the second second nurse of the	F 2	81		

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F 281	**The SSA validated as follows: 1. Record review reassessed by two (2) the incident occurred review revealed Resand physician were ablood sugar result ar hypoglycemia was o immediately. A review MAR revealed blood obtained every hour when the order was physician. Review ophysician orders, andorders were followed 06/29/15 at 11:02 All assessed by two (2) hypoglycemia was sinterview further revesugar was checked of from one hour after the Continued interview Resident #1's physic responsible party were assessed to the continued interview Resident #1's physic responsible party were assessed by two (2)	the Jeopardy was removed vealed Resident #1 was licensed staff members after I on 06/13/15. Further record ident #1's responsible party notified of the resident's low and that treatment for redered and initiated ew of Resident #1's Diabetic glucose levels were until 06/14/15 at 9:00 AM discontinued by the					
	diabetic residents that for were assessed a obtained to ensure the treated appropriately identified by facility so the same of	vealed on 06/13/15 all at LPN #1 had provided care and blood sugar levels were are residents had been and no issues were taff. Interview on 06/29/15 at 43 revealed the LPN had ed blood sugar levels for the ants LPN #1 had cared for and					

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F 281	assessments or with 3. Review of reside all insulin administe licensed staff membresidents' MARs on administrations had nurses. This was vabeing signed off by administration. Inte #4 at 1:36 PM, RN # PM, RN #2 at 1:52 F at 2:01 PM, and RN nurses were require and verify any insuli the preparation of the Interview on 06/29/and the DON on 06/the licensed staff wahave two (2) licensed insulin preparations interview further revithe nursing units on licensed staff that in administration had to licensed staff membresides of the insulin administration werified by two (2) number of the insulin administration of the insulin administration had to licensed staff membresides of the insulin administration werified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at verified by two (2) number of the insulin preparation at the insulin preparation at verified by two (2) number of the insulin preparation at the insulin prepar	nts' Diabetic MARs revealed red was verified by two (2) wers. Review of diabetic 06/29/15, revealed all insulin been verified by two (2) alidated by each insulin dose two (2) nurses for each reviews on 06/29/15 with RN #5 at 1:43 PM, RN #6 at 1:48 PM, RN #8 at 1:56 PM, RN #3 #7 at 2:05 PM revealed the d to have a nurse witness n administration by observing	F 28				

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F 281	and resigned from to 5. Review of the signed Marketing on 06/7 issues were discuss 06/13/15, nursing eincident, system chaily and weekly chabs, orders and insto insulin administration to neadministration. 6. Review of audits compared MARs with insulin supply betwoe The facility did not it the audits. 7. Review of docur staff and the Medicareviews of all diabetwere identified. Into MDS staff and the Moissues were identified. Into MDS staff and the Moissues were identified diabetic care plans. 8. Review of facility nursing staff was eco6/14/15 on the 5 F. Administration. Furnursing staff had to demonstration and Rights of Medicatio 06/29/15 at 2:09 PM licensed staff had b	as suspended on 06/13/15 the facility on 06/16/15. gn-in sheet and agenda for the 15/15 revealed the following sed: medication error on ducation related to the ange related to the incident, lecks of MARs, MAR book sulin, check-off of skills related ation, change in new f-sheet and added return ew hires for insulin a revealed the facility ith physician orders and een 06/14/15 and 06/16/15. Identify any issues related to mentation revealed the MDS al Records RN had completed tic care plans and no issues erviews on 06/29/15 with the Medical Records RN revealed all ducated on 06/13/15 and tights of Medication ther review revealed all of the review revealed all of	F 281			

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F 281	of the post test reversion the test, the staff and the post test ware questions were ansigned. Provided the post test ware questions were ansigned and the post test ware questions were ansigned. Provided the post test was administration will be licensed nurse. The nurses would initial was administered proposervations on 06 PM, and on 06/29/10 of insulin administration of the post of the	cion Administration. A review caled if staff missed an answer if was immediately re-educated as re-administered until all wered correctly on the test. cility policy titled insulin Procedure," revision aled insulin preparation and it validated by another it policy further revealed both on the MAR that the insulin er the physician's orders. If 22/15 at 5:00 PM and 5:10 for at 11:26 AM and 11:35 AM ation, revealed insulin was it facility policy. acility Medication ervation Report revealed servations were completed by Italian and 2:05 PM, the RN in the RN Unit it is in and 2:05 PM, and the vealed all licensed staff erved during medication are 5 Rights of Administration for insulin to be administered by acility's "Daily Insulin in revealed at least one for had been observed daily policy and using the 5 Rights instration during insulin in 6:06/13/15.	F 2	281		

AND DUAN OF CORRECTION IDENTIFICATION NUMBER			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
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F 281	Continued From pag		F 2	281		
	facility Pharmacy Remedication pass obs	ervation Report" revealed the epresentative completed a servation on 06/16/15.				
F 282	were being complete	y audits revealed MAR audits ed by facility staff daily. VICES BY QUALIFIED RE PLAN	F2	282		
	must be provided by	ed or arranged by the facility qualified persons in ch resident's written plan of				
	by: Based on observati and review of the fac- investigation, it was to have an effective services in accordar care for one (1) of th (Resident #1). A rev Resident #1 reveale interventions in place blood sugar checks coverage and medic physician. Review of Report and Investigar revealed Resident # not correct according	determined the facility failed system to provide care and note with the written plan of the gree (3) sampled residents view of the plan of care for		Past noncompliance: no plan correction required.	of	
	Practical Nurse (LPI	oximately 7:30 AM, Licensed N) #1 administered 125 units sulin to Resident #1;				

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F 282	resident (Resident #2 Practical Nurse (LPN) revealed she failed to the insulin to the corre administering the insu AM, Resident #1 begin hypoglycemia (low ble assessed to have a b milligrams per decilite Immediate Jeopardy 06/22/15 and was def 06/13/15. The facility Allegation of Complia alleging the Immediat 06/17/15. Based on the (SSA) validation of the the IJ was removed of initiating the investigat determined to be Pass The findings include: Review of the facility Interdisciplinary Plan revealed the policy di resident's plan of care 1:33 PM with the Direct revealed the facility of to staff following the of Review of the medical revealed the facility of to staff following the of the Minimum Data a reference date of 06	vas ordered for a different). Interview with Licensed) #1 on 06/22/15 at 3:27 PM, verify that she was giving ect resident prior to ulin. At approximately 11:30 an to have symptoms of cod sugar level) and was lood glucose level of 20 er (mg/dL). (IJ) was identified on termined to exist on r submitted an acceptable nce (AOC) on 06/29/15 re Jeopardy was removed on the State Survey Agency's re AOC it was determined on 06/17/15 prior to the SSA ration. Therefore, it was t Immediate Jeopardy. policy titled "Individual and of Care," not dated, d not address following re. Interview on 06/29/15 at rector of Nursing (DON) id not have a policy related readmitted the resident #1 readmitted the resident on	F	282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		COMPLETED	
		185273	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314	l	06/29/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	06/01/15 revealed in stick blood sugar ch coverage and medic physician. Review of Resident 06/04/15, revealed at two times per day at was based on finger results. Review of Resident Administration Recording to the phydid not require sliding administered based sugar. Review of the facility Report and Investigative revealed on 06/13/1 incorrect insulin." Interview on 06/22/17 Practical Nurse (LPI administered insuling at 7:30 AM. LPN #1 book did not contain #1 and Resident #2' look at the name on result, LPN #1 state #2's dose of insuling further revealed medical revealed revealed revealed revealed revealed medical revealed re	days prior to the wof the care plan dated atterventions included finger ecks with sliding scale insulinguations as ordered by the "1's physician orders, dated an order for NovoLog (insulin) according to a sliding scale that restick blood sugar check "1's Medication and (MAR) dated 06/13/15 at AM, revealed Resident #1's milligrams/deciliter (mg/dL). Assician's order, the resident general scale insulinguation attent," dated 06/14/15, and the resident with the	F 28	32		

PRINTED: 08/19/2015 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185273	B. WING			C 06/29/2015	
	ROVIDER OR SUPPLIER			Н	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> 06/</u>	29/2015
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F 282	Continued From page Interviews on 06/22/1 (RN) #1 at 1:44 PM, F 2:05 PM, and LPN #2 medications should a the physician's orders interventions. Interview on 06/22/15 Administrator and DC follow Resident #1's page the incorrect insulin to Administrative staff resident be administered per torders. *The facility implement remove the Jeopardy 1. On 06/13/15, Resident's physician as responsible party were the facility. The facility immediately to Residelevels continued to riside blood glucose level on normal limits at 158. Ordered the withholding day, at which time the again. At that time, the insulin be withheld age (06/15/15). The residemonitoring with blood	5 with Registered Nurse RN #2 at 1:55 PM, RN #3 at 2 at 2:16 PM revealed Iways be administered per 3 and per the care plan 5 at 4:15 PM with the DN revealed LPN #1 did not Dlan of care by administering The the resident. The Evealed medications should the care plan and physician Inted the following actions to Ident #1 was immediately Ilicensed nurses. The Intend the resident's The immediately notified by The provided emergency care The immediately notified by The provided emergency care The immediately notified by The physician one hour the The Resident #1 was within The physician ordered that the The physician ordered on alert The plucose levels checked		282			
	hourly and the Physic followed for Resident and Comprehensive of were reviewed immed	cian Orders were being #1. The Physician Orders Care Plan for Resident #1 diately by the Director of to assure compliance for this					

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F 282	resident. 2. On 06/13/15, the the weekend nurse check all other diabadministered diabed nurse for proper ad and any possible sithad received the preffects noted. 3. Insulin is adminitivalidated by an add 4. The licensed nurimmediately following is no longer employ. 5. The Quality Assit (Committee member Director of Nursing, Records Director, For Coordinators, Social Pharmacy Represerview the plan outlinitial audits and review the plan outli	e Director of Nursing instructed manager to immediately etic residents who had been tic medication by this same ministration of diabetic care de effects. All other residents oper medication with no side stered as ordered and litional licensed nurse. The involved was suspended in the facility. For a continuous continuous care involved was suspended at the facility. For a continuous care involved was suspended at the facility. For a continuous care involved was suspended at the facility. For a continuous care involved was suspended at the facility. For a continuous care involved was suspended at the facility. For a continuous care involved was suspended at the facility. For a continuous care involved was suspended at the facility. For a continuous care involved was suspended at the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and the facility. For a continuous care involved was suspended and litional licensed and litional licen	F 282			
	residents were revie	Care Plans for all diabetic ewed by the MDS Coordinator Records Director (RN) on				

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F 282	conducted for Licen medication administ Medication Administ demonstrations and to validate training of licensed nurses were turn to work until 1 percent of the licensed 6/16/15. Licensed work until education by return demonstrations are sustained compliance of Medication patient, the right dru route, and the right facility's policies that on 06/13/15. 10. The Director of Manager, and the Right completed medication and demonstrations are sustained compliance of medication are sustained compliance.	d 06/14/15, in-services were sed Nurses regarding proper tration using the 5 Rights of tration. Return I post testing were completed on 06/16/15; 2 percent of the re on vacation and cannot training is complete and 98 sed nurses were trained by I Nurses are not permitted to a scompleted and confirmed ation and post test. Inurses are now required to sident, insulin type, and dose on and according to the 5 and Administration (the right time) and according to the twere reviewed and revised Nursing, the RN Unit twere reviewed and revised Nursing, the RN Unit twere reviewed and revised Nursing, the RN Unit twere reviewed and revised in pass observations on all ginning on 06/13/15 through the inition included administration of tration of the 5 Rights of tration. Licensed Nurses are rick until education and return completed. To ensure ce, validation of physician's per and dose will be performed	F 2	282		
	insulin and demons Medication Adminis not permitted to wor demonstrations are sustained compliand orders for insulin typ by an additional lice administration.	tration of the 5 Rights of tration. Licensed Nurses are rk until education and return completed. To ensure ce, validation of physician's be and dose will be performed				

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F 282	Records Director, a	ge 18 hit Manager, the RN Medical and the MDS Coordinators will e administration of insulin daily	F 282		
	Weekend Manager complete these obs	nd the Director of Nursing, , or Charge Nurse will servations on week-ends to cedure and second nurse's			
	conduct Medication	harmacy Representative will Pass observations for monthly consultations until all validated.			
	continue weekly by RN Unit Manager, t Director, and the M (Monday-Friday) ar Weekend Manager	16/13/15, MAR audits will the Director of Nursing, the the RN Medical Records DS Coordinators and the Director of Nursing, or Charge Nurse will servations on weekends.			
	**The SSA validate as follows:	d the Jeopardy was removed			
	assessed by two (2 the incident occurre review revealed Re and physician were blood sugar result a hypoglycemia was immediately. A rev MAR revealed bloo obtained every hou when the order was physician. Review physician orders, a	evealed Resident #1 was a) licensed staff members after ed on 06/13/15. Further record esident #1's responsible party enotified of the resident's low and that treatment for ordered and initiated iew of Resident #1's Diabetic d glucose levels were r until 06/14/15 at 9:00 AM as discontinued by the of the progress notes, and MAR revealed all physician and interview with LPN #3 on			

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F 282	assessed by two (2) hypoglycemia was sinterview further rev sugar was checked from one hour after Continued interview Resident #1's physic responsible party we incident. LPN #3 re were followed. 2. Record review rediabetic residents the for were assessed a obtained to ensure the treated appropriately identified by facility 11:02 AM with LPN assessed and check other diabetic residents there were no issued assessments or with 3. Review of reside all insulin administed licensed staff membersidents' MARs on administrations had nurses. This was vabeing signed off by administration. Intel #4 at 1:36 PM, RN #2 at 1:52 Fat 2:01 PM, and RN nurses were require and verify any insuling the preparation of the sugar was set to the preparation of the sugar was set to t	M revealed Resident #1 was nurses and treatment for started immediately. The ealed Resident #1's blood every hour and was stable the incident occurred. revealed Administrative staff, cian, and Resident #1's ere notified immediately of the evealed the physician orders Evealed on 06/13/15 all at LPN #1 had provided care and blood sugar levels were the residents had been and no issues were staff. Interview on 06/29/15 at #3 revealed the LPN had seed blood sugar levels for the ents LPN #1 had cared for and se identified with the residents' in the blood sugar levels. Ents' Diabetic MARs revealed and was verified by two (2) ers. Review of diabetic 06/29/15, revealed all insulin been verified by two (2) alidated by each insulin dose two (2) nurses for each reviews on 06/29/15 with RN #5 at 1:43 PM, RN #6 at 1:48 PM, RN #8 at 1:56 PM, RN #3 #7 at 2:05 PM revealed the d to have a nurse witness in administration by observing	F2	282		

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Interview on 06/29/2 and the DON on 06/20, the licensed staff was have two (2) licensed insulin preparations interview further revenue for the nursing units on licensed staff that in administration had to licensed staff members of 106/22/15 and 06/29/2 stations revealed a insulin administration verified by two (2) no 06/29/15 at 5:00 PM 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 106/29/15 at 11:26 A insulin preparation a verified by two (2) no 106/29/15 at 11:26 A insulin preparation a verified by two (2) no 106/29/15 at 11:26 A insulin preparation form, revealed LPN #1 was and resigned from the 106/13/15, nursing equincident, system characteristic of 106/13/15, nursing equincident, system charac	15 at 11:02 AM with LPN #3 1/29/15 at 2:09 PM revealed as immediately informed to ad staff members verify all and administrations. The ealed signs were posted on 06/13/15 reminding all sulin preparation and to be verified by two (2) ters. Observations on 1/15 of both facility nurses' sign reminding nurses that all this were required to be the surses. Observations on 1/16 and 5:10 PM, and on 1/16 AM revealed and administration was tursing staff members. Illegation Report and final report dated 06/16/15, as suspended on 06/13/15 the facility on 06/16/15. In sheet and agenda for the 5/15 revealed the following the sed: medication error on ducation related to the large related to the incident, the ecks of MARs, MAR book the sheet and added return where for insulin revealed the facility	F2	282			
	COUNTY HEALTH CARE SUMMARY S (EACH DEFICIEN REGULATORY OF CONTINUED From page Interview on 06/29/1 and the DON on 06/1 the licensed staff was have two (2) licensed insulin preparations interview further reversed the nursing units on licensed staff that in administration had to licensed staff membo 06/22/15 and 06/29/15 and 06/29/15 and 06/29/15 at 5:00 PM 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2) no 06/29/15 at 11:26 A insulin preparation a verified by two (2)	ROVIDER OR SUPPLIER COUNTY HEALTH CARE CENTER, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Interview on 06/29/15 at 11:02 AM with LPN #3 and the DON on 06/29/15 at 2:09 PM revealed the licensed staff was immediately informed to have two (2) licensed staff members verify all insulin preparations and administrations. The interview further revealed signs were posted on the nursing units on 06/13/15 reminding all licensed staff that insulin preparation and administration had to be verified by two (2) licensed staff members. Observations on 06/22/15 and 06/29/15 of both facility nurses' stations revealed a sign reminding nurses that all insulin administrations were required to be verified by two (2) nurses. Observations on 06/22/15 at 5:00 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM revealed insulin preparation and administration was verified by two (2) nursing staff members. 4. Review of the "Allegation Report and Investigation" form, final report dated 06/16/15, revealed LPN #1 was suspended on 06/13/15 and resigned from the facility on 06/16/15. 5. Review of the sign-in sheet and agenda for the QA meeting on 06/15/15 revealed the following issues were discussed: medication error on 06/13/15, nursing education related to the incident, daily and weekly checks of MARs, MAR book tabs, orders and insulin, check-off of skills related to insulin administration, change in new admission check off-sheet and added return demonstration to new hires for insulin	ROVIDER OR SUPPLIER COUNTY HEALTH CARE CENTER, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Interview on 06/29/15 at 11:02 AM with LPN #3 and the DON on 06/29/15 at 2:09 PM revealed the licensed staff was immediately informed to have two (2) licensed staff members verify all insulin preparations and administrations. The interview further revealed signs were posted on the nursing units on 06/13/15 reminding all licensed staff members. 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Review of audits revealed the facility compared MARs with physician orders and	ROUNDER OR SUPPLIER COUNTY HEALTH CARE CENTER, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Interview on 06/29/15 at 11:02 AM with LPN #3 and the DON or 06/29/15 at 1:09 PM revealed the licensed staff was immediately informed to have two (2) licensed staff menimenediately informed to have two (2) licensed staff that insulin preparations and administration. The interview further revealed signs were posted on the nursing units on 06/13/15 reminding all licensed staff that insulin preparations and administrations and of0/29/15 of both facility nurses' stations revealed a sign reminding nurses that all insulin administrations were required to be verified by two (2) nurses. Observations on 06/22/15 at 1:20 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM revealed insulin preparation and administration was verified by two (2) nursing staff members. 4. Review of the "Allegation Report and Investigation" form, final report dated 06/16/15, revealed LPN #1 was suspended on 06/13/15 and resigned from the facility on 06/16/15. 5. Review of the sign-in sheet and agenda for the QA meeting on 06/15/15 revealed to the incident, system change related to the incident, system change related to the incident, system change related to the incident, daily and weekly checks of MARs, MAR book tabs, orders and insulin, check-off of skills related to insulin administration. 6. Review of audits revealed the facility compared MARs with physician orders and	TOUNTY HEALTH CARE CENTER, INC SUMMARY STATEMENT OF DEFICIENCIES (IECAN DETICIENCY WAS TERRETADED AS A BUILDING BY MANY AND	

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F 282	the audits. 7. Review of docum staff and the Medica reviews of all diabet were identified. Interest MDS staff and the Moissues were identified diabetic care plans. 8. Review of facility nursing staff was ed 06/14/15 on the 5 R Administration. Furnituring staff had to demonstration and Rights of Medication 06/29/15 at 2:09 PM licensed staff had betest, and completed 5 Rights of Medicatiof the post test reve on the test, the staff and the post test was questions were answere and the post test was questions were answere administration of Indate 06/13/15, reveal administration will be licensed nurse. The nurses would initial was administered probservations on 06. PM, and on 06/29/1	dentify any issues related to mentation revealed the MDS al Records RN had completed ic care plans and no issues reviews on 06/29/15 with the dedical Records RN revealed tified during the review of the in-services revealed all ucated on 06/13/15 and ights of Medication ther review revealed all perform a return post test related to the 5 a Administration. Interview on I with the DON revealed all pen trained, completed a post a return demonstration of the on Administration. A review aled if staff missed an answer was immediately re-educated as re-administered until all wered correctly on the test. cility policy titled sulin Procedure," revision aled insulin preparation and the validated by another the policy further revealed both on the MAR that the insulin ter the physician's orders. (22/15 at 5:00 PM and 5:10 to at 11:26 AM and 11:35 AM tion, revealed insulin was	F	282		

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10. Review of the fact Administration Obser medication pass obser facility staff from 06/1 Interviews on 06/29/1 Managers at 1:36 PM Medical Records Direct DON at 2:09 PM revements were obser administration for the to be followed and for per the facility policy. 11. Review of the fact Administration form licensed staff member for following facility pof Medication Administration since of the fact Administration Obser facility Pharmacy Remedication pass observations. Review of facility were being complete 483.25(m)(2) RESIDI SIGNIFICANT MED In the facility must ensuring any significant medical.	cility Medication vation Report revealed ervations were completed by 3/15 through 06/16/15. 15 with the RN Unit 1 and 2:05 PM, the RN ector at 1:48 PM, and the ealed all licensed staff rved during medication 15 Rights of Administration 17 insulin to be administered cility's "Daily Insulin revealed at least one 18 rhad been observed daily colicy and using the 5 Rights 19 stration during insulin 106/13/15. cility "Medication vation Report" revealed the presentative completed a 19 ervation on 06/16/15. If audits revealed MAR audits 19 dby facility staff daily. ENTS FREE OF ERRORS ure that residents are free of ation errors.				
This REQUIREMENT by:	「 is not met as evidenced				
	COUNTY HEALTH CARE SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page 10. Review of the fact Administration Obser medication pass obser facility staff from 06/1 Interviews on 06/29/1 Managers at 1:36 PM Medical Records Dire DON at 2:09 PM rever members were obser administration for the to be followed and for per the facility policy. 11. Review of the fact Administration" form licensed staff member for following facility por Medication Adminity administration obser facility Pharmacy Representation pass obser 12. Review of the fact Administration Obser facility Pharmacy Representation pass obser 13. Review of facility were being complete 483.25(m)(2) RESIDI SIGNIFICANT MED I The facility must ensurance of the significant medical This REQUIREMENT	ROVIDER OR SUPPLIER COUNTY HEALTH CARE CENTER, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 10. Review of the facility Medication Administration Observations were completed by facility staff from 06/13/15 through 06/16/15. Interviews on 06/29/15 with the RN Unit Managers at 1:36 PM and 2:05 PM, the RN Medical Records Director at 1:48 PM, and the DON at 2:09 PM revealed all licensed staff members were observed during medication administration for the 5 Rights of Administration to be followed and for insulin to be administered per the facility policy. 11. Review of the facility's "Daily Insulin Administration" form revealed at least one licensed staff member had been observed daily for following facility policy and using the 5 Rights of Medication Administration during insulin administration Observation Report" revealed the facility Pharmacy Representative completed a medication pass observation on 06/16/15. 12. Review of facility audits revealed MAR audits were being completed by facility staff daily. 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	This REQUIREMENT is not met as evidenced IDENTIFICATION NUMBER: A BUILDIN BROWNER CORRECTION A BUILDIN BROWNER: B WING	ROUNTY HEALTH CARE CENTER, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 10. Review of the facility Medication Administration Observation Report revealed medication pass observed during medication administration for the 5 Rights of Administration to the facility policy and using the 5 Rights of Medication administration for the 5 Rights of Administration to the facility policy and using the 5 Rights of Medication administration administration during insulin administration Since 06/13/15. 12. Review of the facility "Medication Administration of Medication administration of Communication of Medication administration of the 5 Rights of Administration administration of the 5 Rights of Administration administration administration during insulin administration of the facility Palmacy Representative completed a medication pass observation and palmacy Representative completed a medication pass observation on 06/16/15. 12. Review of the facility "Medication Administration of Deformation of Medication administration of the 5 Rights of Medication administration of the 5 Rights of Medication administration of the 5 Rights of Medication administration during insulin administration of Servation on 06/16/15. 13. Review of the facility "Medication Administration of Servation on 06/16/15. 14. Review of the facility audits revealed MAR audits were being completed by facility staff daily. 483.25(m/2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	

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		185273	B. WING		C 06/29/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314	1 06/23/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 333	the facility's policy and determined the facility system to ensure on residents (Resident); medication errors. Or:30 AM, Licensed Fadministered 125 unto Resident #1; howefor a different reside with Licensed Practio 06/22/15 at 3:27 PM that she was giving the resident prior to admapproximately 11:30 have symptoms of hevel) and was assessed level of 20 milligrams. Immediate Jeopardy 06/22/15 and was de 06/13/15. The facility Allegation of Complicating the Immediate 06/17/15. Based on (SSA) validation of the LJ was removed initiating the investig determined to be Path The findings include. A review of the facility Administered in according to the attending physical residents were alled residents were residents with the LJ was removed in the	record review, and review of and procedures, it was the failed to have an effective e (1) of three (3) sampled #1) was free of significant on 06/13/15 at approximately practical Nurse (LPN) #1 its of NovoLog 70/30 insuling ever, the insulin was ordered and (Resident #2). Interview call Nurse (LPN) #1 on prevealed she failed to verify the insulin to the correct sinistering the insulin. At AM, Resident #1 began to any yogylycemia (low blood sugar seed to have a blood glucose is per deciliter (mg/dL). (IJ) was identified on extermined to exist on you submitted an acceptable ance (AOC) on 06/29/15 are Jeopardy was removed on the State Survey Agency's the AOC it was determined on 06/17/15 prior to the SSA ation. Therefore, it was st Immediate Jeopardy.	F 333	Past noncompliance: no plan of correction required.	

AND DUAN OF CODDECTION DENTIFICATION NUMBER.		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 333	the medical record, or if necessary verify with other facility per the individual who ad dose should record to resident's Medication (MAR) immediately a given. A review of the Amer Pharmacist handout dated 2011, revealed should always be us to inspect insulin preselection and correct administration to the Areview of the Amer Pharmacist handout Review," dated 2011 be reviewed prior to medication. Continuate revealed the rights of be used which included the right of the with other facility per Review of the medication. Review of the medication with other facility per Review of the medication of the Minimum Data a reference date of the Minimum Data and the medication of the Minimum Data an	the photograph attached to calling the resident by name, ring resident identification sonnel. The policy revealed diministered the medication he administration on the administration Record after the medication was rican Society of Consultant titled "Insulin Injection Tips," da "double check" system ed when administering insulin paration for correct product to dosage before resident. Trican Society of Consultant titled "Medication Pass", revealed the MAR should administration of a led review of the handout of a medication pass should de the right resident, the right dosage and form, the right loute. The handout further the identity should be verified dent's armband, the	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY COMPLETED
		185273	B. WING _			C 06/29/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	Continued From page during the seven (7) assessment. Review 06/01/15 revealed in stick blood sugar che coverage and mediciphysician. Review of Resident: 06/01/15, revealed at two times per day act based on blood gluc 201-250 mg/dL = 2 tunits, 301-350 mg/dl 8 units, and if greate physician. Review of Resident: Administration Recoapproximately 6:00 Ablood sugar was 183 According to the phydid not require slidin administered based level. Review of the facility Report and Investigation.	days prior to the vof the care plan dated terventions included finger ecks with sliding scale insulin ations as ordered by the #1's physician orders dated in order for NovoLog (insulin) ecording to a sliding scale ose results as follows: units, 251-300 mg/dL = 4 L = 6 units, 351-400 mg/dL= r than 400 mg/dL call the #1's Medication rd (MAR), dated 06/13/15 at AM, revealed Resident #1's milligrams/deciliter (mg/dL). Is sician's order, the resident g scale insulin to be on the resident's blood sugar or report titled "Allegation ation," dated 06/14/15,				
	incorrect insulin." Fur investigation revealed approximately 12:00 Director of Nursing (administered 125 unwhich was ordered frapproximately 7:30 Arinvestigation further was no divider in the MARs and the LPN j	d on 06/13/15 at PM, LPN #1 contacted the DON) and reported she had its of insulin to Resident #1,				

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F 333	revealed at approxim "was out of it" so the blood sugar level of a stated the LPN realize the resident the wror investigation reveale pending the investigate resigned on 06/16/18 revealed administrat physician, and Reside of the medication error Interview on 06/22/1 #1's Family Member incident the resident until approximately lufurther revealed the Resident #1 in the hawheelchair by State (SRNA) #1. The Far resident's head was to be "very hot and serve aled the SRNA at this was normal behave a this was normal behave a this was not not was n	#2. The investigation further nately 11:30 AM Resident #1 LPN obtained a finger stick 20 mg/dL. The investigation and at that time she had given and dose of insulin. The dLPN #1 was suspended ation on 06/13/15 and later and the staff, Resident #1's ent #1's family were notified or. 5 at 3:10 PM with Resident revealed on the day of the acted like his/her normal self unchtime. The interview family Member passed allway being pushed in a Registered Nurse Aide mily Member stated the down and he/she appeared weaty." Continued interview asked the Family Member if avior for the resident. The med the SRNA that the mal, so they took Resident and the staff started to treat on be assessed by the serial the staff started to treat on the staff started to trea	F 33		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION	, ,	ATE SURVEY OMPLETED	
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F 333	revealed Resident # during the morning in and out of the res further revealed who out of bed for lunch SRNA noticed a cha SRNA stated she w nurses' station on th passed the resident hallway. SRNA #1 member if the resid. The family member behavior was norma family member and to the nurses' statio Interview with LPN: revealed was lookin 06/13/15 during the needed to be admir Resident #1's blood resident did not req resident's sliding so stated as she contir saw an order for No administered twice medication to Resid MARs did not have #1 and Resident #2 at the name on the the insulin to the wr Interview on 06/22/* #1's Physician reve reported Resident # The Physician state resident had only ha	15 at 12:01 PM with SRNA #1 #1 had been resting in bed but was alert when staff was sident's room. The interview en the staff got Resident #1 and into the wheelchair, the ange in the resident. The as taking the resident by the ne way to the dining room and its family member in the stated she asked the family ent's behavior was normal. denied to the SRNA the al for the resident and the the SRNA took Resident #1 In to be assessed by a nurse. #1 on 06/22/15 at 3:27 PM ag at the diabetic MAR on morning for medications that histered. She stated she saw I glucose results and noted the uire insulin according to the ale that was ordered. LPN #1 hued to look at the MARs, she evolog 70/30 insulin to be daily and administered the lent #1. LPN #1 stated the a divider separating Resident 's MAR, and she did not look MAR and inadvertently gave	F	333		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 333	Physician was very f was aware the reside a scheduled dose of for sliding scale insurevealed when the L what had been admi Physician informed t was administered to for treatment of hypolevel). The Physician orders for the reside hospital; however, si so well to treatment and drinking well she remain in the facility. Interview on 06/29/1 revealed LPN #1 info approximately 11:30 Resident #1 had synthe resident's blood approximately 12:00 stated she was notifi medication error in was LPN #1 informed the notified and treatment stated LPN #1 was in resident care and sufform the facility on 0 further revealed the investigation of the in the Jeopard 1. On 06/13/15, Resident 1. On 06/13/15, Resi	amiliar with Resident #1 and ent did not have an order for insulin and only had an order lin. Continued interview PN informed the Physician nistered to Resident #1 the he LPN the wrong insulin the resident and gave orders aglycemia (low blood sugar in revealed she initially gave ent to be transferred to the nice the resident responded and the resident was eating a allowed the resident to both at AM on 06/13/15 that aptoms of hypoglycemia and sugar was 20 mg/dL. At PM on 06/13/15, the DON end by LPN #1 gave insulin to a ordered for Resident #2. DON the physician was not was provided. The DON mmediately removed from spended and later resigned 6/16/15. The interview DON immediately initiated an incident.	F 33:	3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED C	
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F 333	responsible party w the facility. The faci immediately to Res levels continued to blood glucose level normal limits at 158 ordered the withhol day, at which time t again. At that time, insulin be withheld a (06/15/15). The res monitoring with blood hourly and the Phys followed for Reside and Comprehensive were reviewed imm Nursing on 06/13/15 resident. 2. On 06/13/15, the the weekend nurse	ge 29 ere immediately notified by ility provided emergency care ident #1 and blood glucose rise and within one hour the of Resident #1 was within. On 06/13/15, the physician ding of insulin until the next he physician was notified the physician ordered that the again until the following day sident continued on alert od glucose levels checked sician Orders were being int #1. The Physician Orders is Care Plan for Resident #1 ediately by the Director of 5 to assure compliance for this entire Director of Nursing instructed manager to immediately etic residents who had been	F 333		
	nurse for proper ad and any possible si had received the pr effects noted. 3. Insulin is admini validated by an add 4. The licensed nui immediately following is no longer employ 5. The Quality Assi (Committee member Director of Nursing,	tic medication by this same ministration of diabetic care de effects. All other residents oper medication with no side stered as ordered and itional licensed nurse. The involved was suspended the event on 06/13/15 and the dat the facility. The include the Administrator, Medical Director, RN Medical RN Unit Coordinators, MDS			

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F 333	Coordinators, Social Pharmacy Represe review the plan out initial audits and review the plan out of the Market o	al Services Director, and ntative) met on 06/15/15 to lined herein and results of views. MARs for diabetic residents he Director of Nursing and RN 6/14/15. The MARs were physician's order and then the apply on 06/16/15. The rrect room numbers, and room so validated in the audit 14/15. Care Plans for all diabetic lewed by the MDS Coordinator Records Director (RN) on 15/16/15, in-services were lesed Nurses regarding proper tration using the 5 Rights of litration. Return 15/16/16/15; 2 percent of the re on vacation and cannot training is complete and 98 sed nurses were trained by I Nurses are not permitted to it is completed and confirmed	F 333		
	patient, the right dru route, and the right	n Administration (the right ug, the right dose, the right time) and according to the at were reviewed and revised			

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F 333	Manager, and the R completed medicatic licensed nurses beg 06/16/15. Observatinsulin and demonst Medication Administ not permitted to wor demonstrations are sustained compliant orders for insulin typ by an additional lice administration. 11. Beginning on 06 Nursing, the RN Unit Records Director, arobserve at least one (Monday-Friday) and Weekend Manager, complete these obseconfirm proper process validation. 12. The facility's Phronduct Medication licensed nurses on murses have been validation. 13. Beginning on 06 continue weekly by the RN Unit Manager, the Director, and the ME (Monday-Friday) and Weekend Manager of Weekend Manager of Weekend Manager of Manager	Nursing, the RN Unit N Medical Records Director on pass observations on all inning on 06/13/15 through ion included administration of ration of the 5 Rights of ration. Licensed Nurses are k until education and return completed. To ensure the, validation of physician's the and dose will be performed insed nurse prior to 6/13/15, the Director of the MDS Coordinators will the director of Nursing, or Charge Nurse will the validation on week-ends to the dure and second nurse's armacy Representative will Pass observations for monthly consultations until all the Director of Nursing, the the RN Medical Records	F 333		

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F 333	as follows: 1. Record review reassessed by two (2) the incident occurre review revealed Resand physician were blood sugar result a hypoglycemia was cimmediately. A revimant Arevealed blood obtained every hour when the order was physician. Review of physician orders, are orders were followed (29/15 at 11:02 At assessed by two (2) hypoglycemia was sinterview further revisugar was checked from one hour after Continued interview Resident #1's physic responsible party we incident. LPN #3 rewere followed. 2. Record review rediabetic residents the	the Jeopardy was removed Evealed Resident #1 was licensed staff members after d on 06/13/15. Further record sident #1's responsible party notified of the resident's low and that treatment for ordered and initiated ew of Resident #1's Diabetic d glucose levels were until 06/14/15 at 9:00 AM	F 333	,	
	obtained to ensure to treated appropriately identified by facility 11:02 AM with LPN assessed and check other diabetic reside	he residents had been y and no issues were staff. Interview on 06/29/15 at #3 revealed the LPN had sed blood sugar levels for the ents LPN #1 had cared for and sed identified with the residents'			

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F 333	3. Review of reside all insulin administed licensed staff membresidents' MARs on administrations had nurses. This was vabeing signed off by administration. Intell 44 at 1:36 PM, RN # PM, RN #2 at 1:52 Fat 2:01 PM, and RN nurses were require and verify any insuling the preparation of the Interview on 06/29/1 and the DON on 06/29/1 and the DON on 06/29/1 and the preparations interview further review further re	nthe blood sugar levels. Inthe blood sugar levels. Interest levels. Inthe blood sugar levels. Inth	F	333		
		llegation Report and final report dated 06/16/15, s suspended on 06/13/15				

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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 333	5. Review of the sign QA meeting on 06/1 issues were discuss 06/13/15, nursing e incident, system chadily and weekly chabs, orders and insto insulin administration to neadministration. 6. Review of audits compared MARs with insulin supply between the facility did not in the audits. 7. Review of docur staff and the Medicareviews of all diabetwere identified. Interviews of facility nursing staff and the Moi issues were identified diabetic care plans. 8. Review of facility nursing staff was educated to demonstration. Furnursing staff had to demonstration and Rights of Medication 06/29/15 at 2:09 PM	he facility on 06/16/15. gn-in sheet and agenda for the 15/15 revealed the following sed: medication error on ducation related to the ange related to the incident, ecks of MARs, MAR book sulin, check-off of skills related ation, change in new f-sheet and added return ew hires for insulin a revealed the facility th physician orders and een 06/14/15 and 06/16/15. Identify any issues related to mentation revealed the MDS all Records RN had completed tic care plans and no issues erviews on 06/29/15 with the Medical Records RN revealed all ducated on 06/13/15 and tights of Medication ther review revealed all	F 333		

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F 333	Continued From pa	ge 35 ealed if staff missed an answer	F 333		
	on the test, the staf	f was immediately re-educated as re-administered until all wered correctly on the test.			
	date 06/13/15, reve administration will b	cility policy titled nsulin Procedure," revision aled insulin preparation and e validated by another e policy further revealed both			
	was administered p Observations on 06 PM, and on 06/29/1 of insulin administra	on the MAR that the insulin er the physician's orders. /22/15 at 5:00 PM and 5:10 5 at 11:26 AM and 11:35 AM ation, revealed insulin was			
	medication pass ob facility staff from 06 Interviews on 06/29 Managers at 1:36 P Medical Records Di DON at 2:09 PM re members were obseadministration for the	acility Medication ervation Report revealed servations were completed by /13/15 through 06/16/15. /15 with the RN Unit M and 2:05 PM, the RN rector at 1:48 PM, and the vealed all licensed staff erved during medication ine 5 Rights of Administration for insulin to be administered			
	Administration" forn licensed staff member for following facility	acility's "Daily Insulin n revealed at least one per had been observed daily policy and using the 5 Rights nistration during insulin e 06/13/15.			
	12. Review of the f	acility "Medication ervation Report" revealed the			

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F 333	facility Pharmacy Rep medication pass observable. 13. Review of facility	presentative completed a	F3	333		